NHS North West

Northwest Management of Termination for Fetal Anomaly Guideline

For Stillbirth, please see Northwest Regional Guideline on Management of Stillbirth, version 5.0, April 2025.

Guideline produced on behalf of the Northwest regional maternity team

Designed and created with babies and their families at the centre to help ease their suffering whilst honouring their baby's memory

Version 1 April 2025

The North West Regional Guidelines have been created with experts from the region to provide the best evidence based practice for all our service users. We understand units have their own templates reflecting their individual institutions' governance requirements however when transferring the guideline the authorship, issue date, content and review date must remain the same.
In addition, deviations from practice recommended in the regional guideline should be discussed with the Regional Guideline Group.

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Version control:

Title	Action	Date
V1	First draft	March 2025

Compliant with:

1.	Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales. RCOG, 2010.
2.	Position statement following Chief Coroner's Guidance no. 45, "Stillbirth and Live Birth Following Termination of Pregnancy" Advice for clinicians following abortion care at later gestation. RCOG, 2023.

Acknowledgements:

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Conflict of Interest:

Kate Navaratnam is a member of the RCOG Guidance Committee, author of Termination for Fetal Anomaly (in development) and co-author of the RCOG Position Statement on Livebirth after Termination of Pregnancy. She is a member of the BMFMS committee and a co-author of the British Maternal-Fetal Medicine consensus statement on fetal awareness (in development).

Contents

1 Introduction

This is the first edition of Northwest regional guidance on termination of pregnancy for fetal anomaly (TOPFA) and follows a working party group report on the same subject published by the Royal College of Obstetricians and Gynaecologists (RCOG) in 2010. A comprehensive, updated and localised guidance format is required for Northwest Fetal Medicine Specialists.

Termination of pregnancy remains a topic for international debate, with several countries including the US taking recent measures to restrict legal access. There have also been recent approaches to parliament to challenge UK law, and it is timely to develop clear guidance that best supports women and families and assists professionals.

Advances in screening and diagnosis have important implications for TOPFA, namely the introduction of non-invasive prenatal testing (NIPT) and prenatal exome sequencing (pES). Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) reports describe maternal deaths following feticide procedures and best practice guidance for professionals would support management of this rare but important risk, as well as maternal morbidity associated with TOPFA, which is likely to be more frequent but less reliably captured by reporting systems. It is important that there is uniformity and clarity in this area to mitigate adverse outcomes.

2 Purpose

This guideline will outline;

- The legal framework and grounds for termination
- Screening and diagnosis of fetal anomalies in relation to termination
- Optimising support for parents
- Management options after identification of fetal anomalies
- The role of feticide and methods
- Methods for medical termination and access to surgical termination
- Post termination care and investigations, including access to perinatal pathology and debriefing
- Staff support, for teams providing care around termination

3 Scope

Women undergoing termination for fetal anomaly (Ground E – where there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped[5]).Most women will have singleton pregnancies with anomalies identified at the anomaly scan ($18+^{0}$-$21+^{6}$ weeks), though there are an increasing number of early second trimester and third trimester diagnoses. This guidance will not exclude women identified with anomalies in multiple pregnancies and will link to other relevant guidance for these women.

This guideline will not apply for women accessing termination under other grounds, e.g. maternal mental or physical health, social circumstances or for termination care in the independent sector. However, we acknowledge that some women access TOPFA in the independent sector, in particular when choosing surgical termination options.

4 Responsibilities

Primarily Fetal Medicine Specialists and all specialists involved in termination care in their roles, including Obstetricians and Gynaecologists. Postgraduate doctors in Obstetrics and Gynaecology. Fetal Medicine Midwives and Midwives involved in termination and bereavement care in their roles. This guidance may also inform doctors working in general practice.

5 MAIN GUIDELINE CONTENT

5.1 Background and Epidemiology

In 2021, 214,256 terminations took place for women resident in England and Wales, with 77% occurring in the independent sector, under Ground C[1]. Overall, 1.6% of terminations took place under Ground E, an increase from 1% in the prior year[1]. Of terminations taking place under Ground E, 25% take place at or beyond $22+^{0}$ weeks, at gestations where feticide, a procedure to stop the fetal heart prior to delivery and prevent livebirth, is advised. Morbidity data for feticide is poorly captured by UK reporting systems, however there are consistent reports of maternal death following feticide in Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries Across the UK (MBRRACE-UK) reports[2]. The last reported deaths were included in the 2019-2021 report where two women died due to post-feticide sepsis[2].

In 2021 there was also a notable decrease in women undergoing medical termination of pregnancy (MTOP) from 80% to 65%[1]. This may be reflective of women's increasing knowledge and choice for surgical termination of pregnancy (STOP) in individual circumstances and more women in the population having had previous caesarean births.

5.2 The Legal Framework for Termination for Fetal Anomaly in the UK

An abortion or termination of pregnancy is a medical or surgical procedure to end a pregnancy. The law relevant to termination of pregnancy is contained in four different Acts of Parliament: the Offences Against The Person Act 1861[3], the Infant Life (Preservation) Act 1929[4], the Abortion Act 1967[5] and the Human Fertilisation and Embryology Act 1990[6].

The Offences Against The Person Act 1861, Section 58, prohibits unlawful induction of a miscarriage[3]. The Infant Life (Preservation) Act 1929 made it an offence to 'destroy the life of a child capable of being born alive'[4]. The Abortion Act 1967 creates defences to the Offences Against the Person Act and the Infant Life (Preservation) Act[4,5,6]. The Abortion Act sets out grounds and time limits for termination of pregnancy to be lawful[5]. The Abortion Act 1967 also stipulates that a pregnancy can only be terminated where two registered medical practitioners agree, in good faith (except in an emergency), that one of the grounds are met[5].

The 1967 Abortion Act was amended in 1990 by the Human Fertilisation and Embryology Act, which introduced a time limit on most terminations after 24 weeks gestation but permitted termination for serious fetal anomaly without gestational age restrictions[5,6]. The grounds are set out in Sections 1(1) (a)–(d) of the Abortion Act[5]. The abortion notification form refers to these as Grounds A to G [Figure 1].

In March 2022 an amendment was made to the Health and Care Bill allowing women to take Mifepristone and Misoprostol at home up to 9 weeks gestation, this confirmed a permanent change to the Bill, following temporary changes introduced during the COVID-19 Pandemic.

Ground	Definition
Ground A	That the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated.
Ground B	That the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman.
Ground C	That the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman.
Ground D	That the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing child(ren) of the family of the pregnant woman.
Ground E	That there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.
Ground F	To save the life of the pregnant woman.
Ground G	To prevent grave permanent injury to the physical or mental health of the pregnant woman.

Figure 1. Grounds for termination in the 1967 Abortion Act[5].

How are substantial risk and serious handicap, referred to in Ground E defined?

Though substantial risk is included in the wording of Ground E, there is no legal definition of what constitutes substantial risk. The perception of substantial risk is dependent on the fetal condition, likelihood of the risk outcome occurring and individual attitudes to this risk.

Similarly, there is no legal definition of serious handicap and the 2010 working party group report concluded that it would be unrealistic to produce a definitive list of conditions that constitute serious handicap[7].

An individualised assessment of risk of serious handicap should take place, with appropriate input from maternal-fetal medicine specialists. For complex and/or rare pathologies a comprehensive assessment should also include input from neonatal and relevant paediatric specialists.

Evaluation of risk of serious handicap should take account of the following factors;

- the potential for effective treatment, either in utero or after birth
- on the part of the child, the probable degree of self-awareness and of ability to communicate
- with others
- the suffering that would be experienced
- the probability of being able to live alone and to be self-supportive as an adult on the part of society, the extent to which actions performed by individuals without disability that are essential for health would have to be provided by others

What are the responsibilities of conscientious objectors in relation to Termination for Fetal Anomaly?

Section 4 of the Abortion Act 1967 allows for conscientious objection, and doctors can choose not to participate in terminations. However, they are responsible for providing treatment required to save the life or to prevent grave permanent injury to women. Doctors have a right to conscientiously object, and patients are entitled to receive objective, non-judgmental medical advice and treatment.

The General Medical Council (GMC) states that "You must explain to patients if you have a conscientious objection to a particular procedure[8]. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right[8]. In providing this information you must not imply or express disapproval of the patient's lifestyle, choices or beliefs[9]. If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role"[9].

The Nursing and Midwifery Council (NMC) mirrors this advice, the NMC Code states that a conscientious objector must "tell colleagues, their manager and the person receiving care that they have a conscientious objection to a particular procedure" and arrange for a suitably qualified colleague to take over responsibility for that person's care"[10].

The British Medical Association (BMA) has outlined further guidance on the law and ethics of abortion and professionals' personal beliefs[11,12]. Professionals involved in care around termination of pregnancy should be familiar with their legal and professional responsibilities to women and their team members. Teams providing care around termination of pregnancy should establish pathways that ensure timely access to termination and are respectful to women's choices and professionals individual beliefs. The NMC is explicit in stating that " midwives and nursing associates to make sure they do not express their personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way. This expression may be in any format including though the use of social media"[10].

5.3 Screening and Diagnosis of fetal anomalies in the UK

The UK National Screening Committee (UKNSC) produces UK-wide screening policies, and each country determines how to implement these policies. UKNSC policies set standards for all professionals involved in screening to ensure high quality information and screening options for fetal aneuploidy and structural anomalies are available.

Most fetal anomalies are identified during screening, but an increasing number of anomalies are now being identified from private non-invasive prenatal tests, private ultrasound examinations and clinically indicated third trimester ultrasound, usually arranged for assessment of fetal growth.

Regarding fetal anomalies, all pregnant women are currently offered screening for;

- Aneuploidy (Trisomy 21, Trisomy 18, Trisomy 13)
- Structural anomalies

Aneuploidy screening

The preferred screening test for Trisomy 21, 18 and 13 is the combined test, a combination of maternal age, nuchal translucency measurement and serum biomarkers; Human Chorionic Gonadotrophin (HCG), Pregnancy-associated plasma protein A (PAPP-A), between 10- and 14-weeks' gestation[14]. The crown rump length of the fetus must be between 45 and 84 mm to obtain an appropriate nuchal translucency (NT) for the combined test. Where women book beyond the 14-week threshold, the crown rump length exceeds 84 mm or nuchal translucency cannot be accurately obtained, the quadruple test (AFP, HCG, uE3, Inhibin-A) can be offered as an alternative between 14- and 20-weeks' gestation[14]. At the time of writing, the quadruple test does not report a Trisomy 18 or 13 chance[14].

Women who receive a high chance (>1:150) of Trisomy 21, 18 or 13 have the option of further high-performing aneuploidy screening with a non-invasive prenatal test (NIPT) that screens

for Trisomy 21, 18 and 13 or referral to fetal medicine for assessment and prenatal diagnosis[14]. The advised diagnostic test, for women that choose this option, is dependent upon ultrasound findings and the nature of the aneuploidy. This is as both NIPT and CVS assess trophoblastic DNA and there is a small (1-2%) chance of confined placental mosaicism with chorionic villus sampling (CVS). Where there is an early fetal anomaly (e.g. cystic hygroma) correlating with NIPT findings a CVS, from $11+^{0}$ weeks is reasonable where the QF-PCR is performed in an ACGS accredited laboratory. Otherwise in instances of higher chance of Trisomy 13 or 18, where no anomaly is identifiable on ultrasound an amniocentesis should be offered. This can be offered from $15+^{0}$ weeks. Women that have had a previous aneuploid pregnancy have access to direct NIPT screening and/or the option of prenatal diagnostic testing[14]. This will be elaborated further in upcoming RCOG NIPT Guidance in 2025.

Screening for structural anomalies

Most fetal structural anomalies are detected during the second trimester at the fetal anomaly scan ($18+^{0}$ – $20+^{6}$ weeks)[15]. Some anomalies will be detectable at the dating scan, and earlier detection is continuing to improve[16]. However, it is important to note that some anomalies are not detectable until later gestations and others may only be apparent after birth.

The Fetal Anomaly Screening Programme (FASP) outlines a base menu of required images and records to be made, which includes a fetal cardiac protocol, for the anomaly scan[15]. FASP also sets expected detection rates for a range of fetal anomalies, with which to illustrate performance of screening and to target improvements[17]. Where base menu images cannot be completed, a single repeat examination must be offered and completed by $23+^{0}$ weeks[15].

Fetal medicine and diagnostic tests

Where screening identifies a structural anomaly, referral to a fetal medicine specialist has been demonstrated to improve diagnostic accuracy. The certainty of diagnosis is important in determining prognosis and providing the correct information to facilitate women to make decisions on further investigations and management of their pregnancy. Dependent on the unit in which the woman is booked in and the specific concern, further assessment may require review by a local fetal medicine specialist (District General Hospital) and/or referral to the Fetal Medicine Unit (Tertiary Centre). Further clinical assessment, including (i) specialist ultrasound examinations; prenatal diagnostic testing (CVS, amniocentesis and/or others) and fetal magnetic resonance imaging (MRI) may be performed or recommended. Prenatal exome sequencing (pES) is available as a diagnostic test within the NHS England care pathway, when specific phenotypic eligibility criteria are met and only when a genomic diagnosis would guide management of the fetus or neonate[13]. Eligibility, informed consent and confirmation that testing can proceed must be agreed by a Consultant Clinical Geneticist[13].

Cheshire and Mersey and Greater Manchester Fetal Medicine Networks manage cases within regional multidisciplinary teams. The regional MDTs meet weekly to review images, discuss cases and agree further investigations and management. The MDTs have representation from fetal medicine specialist, prenatal genomic specialists, fetal/paediatric radiology, neonatology, paediatric palliative care and other paediatric specialities for individual cases. The Cheshire Merseyside, North Wales and Isle of Man Fetal Medicine MDT takes place weekly on Wednesday 0830-0930, on Teams and face-to-face in the Fetal Medicine Unit, Liverpool Women's Hospital, Liverpool. The Greater Manchester and Eastern Cheshire Fetal Medicine MDT takes place weekly, on Thursday 0830-0930, on Teams and face-to-face in the Fetal Medicine Unit, St Mary's Hospital, Manchester. Cases reviewed in the tertiary centres are discussed and direct referrals for discussion from regional units are also encouraged. Colleagues in all regional units are invited to attend regular MDTs.

Discordant Fetal Anomalies in Multiple Pregnancies

Where there is a discordant fetal anomaly in a multiple pregnancy, the woman should be

referred to the tertiary centre (Liverpool Women's Hospital for Cheshire and Mersey referring units and St Mary's Manchester for Greater Manchester and East Cheshire referring units) for review and further discussion of options with a Subspecialist Consultant with experience investigating and managing discordant anomalies.

All confirmed cases of discordant structural anomalies and/or genetic abnormalities should be referred for discussion at regional Fetal Medicine MDTs coordinated by Liverpool Women's Hospital and St Mary's Hospital. The referring Fetal Medicine Consultant and team are encouraged to attend and contribute to discussion and shared management planning. Any actions from MDT discussion will be shared with local Fetal Medicine Team. During MDT presentation of the case, imaging of anomalies and chorionicity will be shared. The MDT must proceed with caution when fetuses are of the same sex, same placental sites and/or there are any concerns with chorionicity imaging. In this case the pregnancy will be managed as monochorionic, unless additional evidence becomes available. A summary of the MDT opinion and agreed options to offer, e.g., selective feticide, gestational age to offer and by which method, plus names of Fetal Medicine Consultants present will be recorded in the patient's electronic record and shared with the referring Fetal Medicine Team.

Where any concern with assigned chorionicity is identified, double amniocentesis with zygosity testing will be advised before offering selective feticide with an injectable feticide agent. This is due to the risk of harm or demise of a co-twin in an unidentified monochorionic pregnancy. Where this is not agreed (or feasible) alternatives suitable for a monochorionic pregnancy will be considered.

5.4 Support for women and families following diagnosis

The diagnosis of a fetal anomaly, and resultant pregnancy loss or decision for termination, is associated with short term and longer-term anxiety and depression. This may affect women, partners and family members. This can be challenging where there is a discordant anomaly in a multiple pregnancy.

Teams caring for women where fetal anomalies are identified should work with the aim that women and families are well supported during investigations, termination procedures, delivery, postpartum and into future pregnancies. During appointments in Fetal Medicine, women should be encouraged to be accompanied by their partner or another supportive person, if they would find this helpful. Valuable support can be provided by fetal medicine midwives and doctors, and prioritising continuity of carers is an important initial step in delivering good quality support.

Fetal medicine teams should share contact information for other appropriate information and support services e.g. Antenatal Results and Choices, that provide advice, and support, including group peer support. Organisations/charities specific to the fetal diagnosis can also offer valuable support, and signposting to local peer groups. Additional support can be accessed from bereavement teams and local children's hospices with perinatal services, dependent on the situation. However, access to specific psychological support is variable and should be prioritised for development.

Women and their families should be given the option to meet with a member of the bereavement team to discuss care for them and their baby. If families decline this then the bereavement team should still be informed of the ladies' admission. It may be appropriate to give the families a tour of the unit and or labour ward, so they are prepared for their admission.

At admission appropriate staff (including reception staff) should be informed of the woman's admission and the sensitivity of the situation to aid communication and the experience for the woman, partner and their family. Whilst in hospital during induction and postnatally, women and families should be cared for in a suitable bereavement suite, that allows them appropriate privacy in a comfortable environment, but with continuous midwifery and obstetric care. Every

effort should be made for the partner/family to remain with the woman as long as she wishes, and length of stay should be individualised.

The death of a baby will be distressing not only for the mother but for both parents (where applicable) and potentially for the wider family members (including siblings). It is important to ensure that all are well supported throughout the hospital stay and beyond, with as much continuity of care as possible. Women who have experienced fetal or neonatal loss are at risk of depression, but those with a previous psychiatric disease or of a vulnerable social group are at particular risk.

Professionals caring for grieving families should ask if there are any religious or cultural customs which are important to them. Women and families may wish to involve their religious leader or meet a member of the hospital chaplaincy. Professionals caring for women following any pregnancy loss, including TOPFA, should familiarise themselves with how to refer to hospital chaplaincy and support women and families in making these referrals, if they decide to opt for this.

Further information on religious practices is available at;
https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2017/06/NWNODN-Religious-Practices-.pdf

Many Northwest Trusts hold an annual Remembrance Services. Women and Families that have experienced TOPFA may wish to attend these services and information about them should be shared.

5.5 Management options to be considered following diagnosis of a fetal anomaly

Management options for the pregnancy should be discussed after detailed assessment in fetal medicine that may include diagnostic test results and findings of any additional imaging. A balanced overview of options should be presented, that are tailored to the fetal condition and expected impact. This discussion should include the woman's partner and/or other support person/people if she wishes. Time should be allowed to process this information and ask questions, both whilst in the department and after returning home. Women should be provided with contact details for the STAR midwife and specialist (e.g. Clinical Geneticist, Genetics Counsellor), if appropriate to the fetal condition. A plan for a welfare call from the STAR Midwife, or fetal medicine clinic follow-up can be agreed with the woman following initial counselling.

Management options include;

- Continuing pregnancy with MDT care. This usually includes surveillance of the fetal condition, growth and wellbeing, tailored information about the fetal condition from the Fetal Medicine Specialists and other relevant specialists, if helpful. Individualised birth planning should also take place, with delivery planned at term where medically/obstetrically appropriate, which may include parallel planning or palliative planning for the neonate.
- Not continuing the pregnancy (singleton pregnancy) or selective termination (multiple pregnancy). In most cases this will be a termination under Ground E of the Abortion Act, provided the criteria for Ground E are met by the fetal condition. However, less than $24+^{0}$ weeks, women have a choice for termination under Ground C and should be made aware of this alternative in UK law. Appropriate follow-up and bereavement support should be offered.
- Specialist review and counselling about options with a Subspecialist Consultant with experience with selective termination should be arranged for all women with a multiple pregnancy and discordant fetal anomaly. Where women have a monochorionic multiple pregnancy and are considering TOPFA, they should be referred to Liverpool

Women's Hospital Multiple Pregnancy Clinic, where these procedures can be accessed.

Seeking a second opinion for termination for fetal anomaly

If termination for fetal anomaly is requested, and after specialist assessment and counselling the assessing clinician(s) are not able to support this, they should support the women in obtaining a second opinion, without delay. The case should be discussed with colleagues within the unit, if in a District General Hospital, advice should be sought from the tertiary centre. If within the tertiary centre, the case should be discussed with subspecialist colleagues. The regional MDTs are a forum to provide shared decision-making for these cases, and to allow relevant input from other specialists (e.g., clinical genetics, paediatric specialities). If after MDT discussion termination still cannot be supported, a second opinion should be facilitated from another tertiary centre with the woman's consent. We advise, discussion can be facilitated without delay, at the MDT of the alternative Northwest tertiary centre (women assessed in St Mary's requiring second opinion can be discussed at LWH MDT and the converse). Arrangements can be made to review in person following this discussion. In some cases, including if the woman prefers, the second opinion may be sought from a tertiary centre outside the Northwest and the team in the tertiary centre should facilitate contact with another unit, where possible, to support the patient in this process.

5.6 Methods of termination of pregnancy to be discussed with women

The fetal medicine specialist should explain the options of medical termination of pregnancy (MTOP) and surgical termination of pregnancy (STOP), taking into consideration the risks and benefits of each option, and any possible medical contraindications. Both methods are very safe; the table below outlines possible risks. Parents need clear explanations so that they can decide which method will work best for them.

Complications and risks of abortion

abortion-care-best-practice-paper-april-2022.pdf

Complication/risk	Medical abortion	Surgical abortion
Continuing pregnancy	1–2 in 100	1 in 1000 Higher in pregnancies <7 weeks
Need for further intervention to complete the procedure	<14 weeks: 70 in 1000 >14 weeks: 13 in 100	<14 weeks: 35 in 1000 >14 weeks: 3 in 100
Infection*	Less than 1 in 100	Less than 1 in 100
Severe bleeding requiring transfusion	<20 weeks: less than 1 in 1000 >20 weeks: 4 in 1000	<20 weeks: less than 1 in 1000 >20 weeks: 4 in 1000
Cervical injury from dilation and manipulation**	–	1 in 100
Uterine perforation	–	1–4 in 1000
Uterine rupture	Less than 1 in 1000 for second-trimester medical abortions***	–

* Upper genital tract infection of varying degrees of severity is unlikely but may occur after abortion and is usually associated with pre-existing infection. Infection after surgical abortion is reduced with use of prophylactic antibiotics.

** Cervical injury is less likely if cervical preparation is undertaken in line with best practice.

*** The presence of a uterine scar (e.g. following a previous caesarean) is a risk factor.

Whilst access to both methods with NHS providers is good in the first trimester, access to STOP varies for women from 13+0 weeks and this may not be feasible in some units within the region. Cases that do not meet the eligibility criteria outline in the unit's STOP SOP/Guidance should be discussed with the unit lead for Termination or follow the unit's SOP, if one is in place.

The majority of STOP over 13 weeks are provided for by the independent sector providers (ISPs) such as British Pregnancy Advisory Service (BPAS), Marie Stopes International (MSI), National Unplanned Pregnancy Advisory Service (NUPAS) under NHS contracts, and increasingly there are pathways in place for onward referral to the ISPs for women with FA. In Manchester, MSI provide such a service, whereas in Liverpool BPAS hold the contract.

STOP can be carried out up to 18+6 in St Mary's, Manchester, however capacity is limited and should primarily be used by women who are not eligible for care in the ISPs, such as those with haematological disorders or cardiac disease. The team in Manchester can be contacted at **mft.whitworthclinic@mft.nhs.uk 0161 276 6283**. STOP can be accessed by referral to other NHS Providers such as Newcastle, Birmingham and London for those requesting STOP from 19 up to 23+6 weeks.

It should be discussed with women that the methods used for STOP will mean post-mortem examinations are not feasible. Where MTOP or STOP are carried out in the independent sector (e.g. BPAS, Marie Stopes) it may not feasible to obtain cytogenetic samples for testing or arrange post-mortem following MTOP, unless an individual arrangement can be made with the independent termination provider to obtain the sample. Results of these investigations may be useful for counselling about the fetal diagnosis and providing accurate information to counsel on chances of recurrence and management in a future pregnancy.

Help with counselling women faced with choosing between medical and surgical TOP. Each method whilst safe, has varying pros and cons that should be discussed with each patient and an individualised decision and care plan created. Here are some useful points to make whilst counselling each patient (reproduced with permission from; ARC-Parent-Centred-Guidelines.pdf

Medical TOP

- 2 stages of medical treatment, given over 3-4 days
- Need for inpatient stay on either gynaecology ward or delivery suite
- Will be given private room, so can have partner or friend/ family with them
- Medicines given will cause painful contractions and bleeding, and the women will deliver the baby.
- Various drugs can be given to help with the pain.
- Usually the women will have to stay overnight during the second stage of treatment.
- There are options to see and hold the baby after delivery, and to provide memory making for the family
- There is the option to have a post mortem on the baby, which may help provide information for future pregnancies.
- Occasionally the baby may be born with signs of life, and this can mean the baby's birth and death needs to be registered and the coroner informed.
- There may be the need to carry out a feticide if the MTOP is taking place beyond 22 weeks gestation.
- About 5% of women will have a retained placenta, which can cause bleeding, the need for an operation or a blood transfusion.

Surgical TOP

- May need referral to ISP or other NHS provider for treatment
- The operation will usually be carried out under general anaesthetic as a day case procedure. The method of surgical TOP will depend on gestation- vacuum aspiration if under 14 weeks, dilatation and evacuation between 14 and 24 weeks.
- The patient is likely to require cervical preparation on the day or day before.
- They may require feticide if having STOP over 22 weeks.
- The risks of complications include bleeding and retained tissue.
- They will be unable to have a post mortem on the baby, but should be able to have genetic testing on the placenta.
- Memory making will be limited and they will be unable to hold the baby afterwards.
- They have option of taking pregnancy remains or asking funeral director to be involved.

Method of surgical TOP

Vacuum aspiration up to 14 weeks- procedure is performed by carefully dilating the cervix and then passing suction tubing into the uterus and removing the pregnancy tissue using vacuum aspiration.

Dilatation and evacuation is performed from 14 weeks up to 23+6. Following cervical preparation, the cervix, instruments are passed into the uterine cavity to break the waters and remove the fetus and placenta under ultrasound guidance.

A useful summary sheet can be found on the RCOG with more information regarding Surgical TOP after 14 weeks. 4580-rcog-summary-sheet_surgical-abortion-before-14-weeks-summary-sheet-v3.pdf

5.7 The role of feticide

Feticide is a procedure to reliably stop the fetal heart prior to induction of labour, where termination of pregnancy has been decided. The purpose of feticide is to prevent livebirth and potential for longer term survival after birth. There is no legal requirement for feticide as part of legal termination of pregnancy in UK law. However, termination where livebirth and longer-term survival is feasible e.g. gestational age from 22 weeks and non-lethal and potentially survivable anomaly(ies) is counter-intuitive to the decision for termination and unlikely to be acceptable to fetal medicine specialists.

Livebirth after termination can generate significant distress for women and families, raise challenges for obstetric and neonatal teams and impact requirements for registration (livebirth and neonatal death vs. stillbirth). Livebirth after termination triggers a Coroner's enquiry, that may progress to an inquest[18].

Chances of livebirth are dependent on fetal condition (diagnosis and gestational age) and termination method. The chance of livebirth increases with increasing gestational age and potential for longer term survival also increases (beyond $22+^{0}$ weeks)[19]. A UK based registry study reported livebirths following medical termination for fetal anomalies between 1995 and 2004. Of n=3189 MTOPs n=102 (3.2%) livebirths occurred[20]. Between 16 and 20 weeks, 3.5% were born with signs of life, compared to 5.4% at 21 weeks, 6.4% at 22 weeks and 9.7% at 23 weeks[20]. Since these data were published, reporting of signs of life has continued to increase[21].

The RCOG states that where birth is likely to occur[19];

- **>21+^{6} weeks** feticide is recommended
- **20+^{0} to 21+^{6} weeks** where women are concerned about the chance of livebirth after individualised counselling, it is reasonable to discuss the option of feticide, but it should not be recommended due to lower overall chances of livebirth.
- **<20+^{0} weeks** feticide should not be routinely offered. These procedures are technically more difficult, and serious procedure-related maternal risks outweigh potential benefits of the procedure where there is no chance of survival due to early gestational age.

Where feticide is being requested by women less than 22 weeks in the region, it is important to consider the potential added case load of these procedures and devise appropriate pathways to ensure access to termination is not restricted.

Efforts should be made to establish and maintain effective working relationships with local Coroners to facilitate prospective discussions in more challenging situations[19]. Where feticide is declined there is an increased chance of a livebirth, and it is advised that this should be prospectively discussed with the coroner. It is also valuable to have local pathways in place to guide staff and plan for palliation if a livebirth does occur. This plan should include not calling for neonatal resuscitation[22]. In these cases, discussions with women and families, the agreed plan management should livebirth occur and discussions with the coroner should be carefully documented.

Assessment of signs of life following birth must be discreet and respectful, and the individual needs of the neonate, the woman and her partner should be prioritised. It is preferable, in the context of abortion, for the neonate to be seen by members of the midwifery and obstetric teams rather than the neonatal team[19].

Assessment should be based on persistent, readily evident, visible signs. Listening for a heartbeat with a stethoscope or palpation of the umbilical cord is not necessary. Signs of life after birth include one or more of the following[19]:

- Easily visible heartbeat seen through the chest wall
- Visible pulsation of the cord after it has been clamped
- Breathing
- Crying or sustained gasps
- Definite movement of the arms and legs

Fleeting reflex activity including transient gasps, brief visible pulsation of the chest wall or brief twitches or involuntary muscle movement can be observed in neonates that have died shortly before birth and should not be considered as representing signs of life when observed in the first minute after birth.

In England a doctor can determine signs of life witnessed by them. If they do not witness signs of life, they must discuss with the attending healthcare professional and decide together whether signs of life were present (discussing the above signs). This discussion can include the woman's observations and views. If the doctor did not witness the signs of life, they must inform the coroner to allow a neonatal death certificate to be issued.

5.8 Documentation and registration

- The use of electronic or pre-printed written consent is advised for feticide, MTOP and STOP procedures.
- The HSA1 form (Form A) and HSA2 form are paper forms for practitioners to certify

their opinion on the grounds for termination (see links in section 7.1). The HSA1 form should be completed by two doctors that agree that criteria for Ground E of the abortion Act are met. HSA2 may be used for emergency termination. The doctor with primary responsibility (usually the doctor performing the feticide or with responsibility for the patient) should add their details and signature to the HSA4 form which is used to inform the Chief Medical Officer that a termination has taken place (see link in section 7.1). The HSA4 may be completed online or on paper and returned to the Department of Health and Social Care (DHSC). Access to online reporting can be obtained via hsa4@dhsc.gov.uk.

- A medical certificate of stillbirth is a legal requirement in all cases of stillbirth from $24+^{0}$ weeks gestation, including where termination has taken place (see information link in section 7.2). The stillbirth certificate is to be completed by a doctor or midwife who has delivered the baby or examined the baby after birth. If there is any uncertainty of cause of death, clarity should be sought from a senior clinician. The direct cause, antecedent causes and other significant conditions that are recorded on the stillbirth certificate should also be recorded in the maternal medical record. Reference to the ReCoDe classification (Relevant Condition at Death) is a useful guide to ensuring that accurate information is recorded here (see link in section 7.2 for classification). The stillbirth certificate should be forwarded to the local registry office by the hospital bereavement team (see local policy as stillbirth certificate may be required to be emailed to the registry office or Trust bereavement office). Women should be supported with the registration process by the hospital bereavement team.
- Baby loss certificates are available for any pregnancy loss less than $24+^{0}$ weeks, including following termination and this option should be discussed with women (see link in section 7.2).

5.9 Recommended procedures for feticide

Before the procedure

- Feticide procedures should be appropriately planned and scheduled to take place in the Fetal Medicine Unit.
- For both monochorionic and dichorionic multiple pregnancies, selective termination procedures are advised either <14 weeks or during the third trimester (advisably >32 weeks, following antenatal steroid administration, though this should be agreed on an individual basis). These time periods are specified due to the risk of pregnancy loss or extreme preterm prelabour rupture of membranes and preterm birth due to procedures performed in the second trimester.
- Arrangements should be made for the woman to be accompanied by her partner or other support person throughout, with appropriate privacy. Provision should be made for one-to-one midwifery care. Full information should be provided on what to expect, informed written consent is required in addition to completion of HSA1 and HSA2 documentation (see Appendix) and arrangements for delivery and follow-up discussed and agreed.
- The option of oral maternal sedation (e.g., 2mg Lorazepam) should be discussed with the woman. If a woman chooses to have pre-procedure sedation, sufficient time allowed for this to take effect prior to commencing the procedure (e.g., 30 minutes for Lorazepam) and a resuscitation trolley should be available within the department it is administered. Due to the variable length of feticide procedures, which is dependent on individual factors, maternal local anaesthetic infiltration is advised. This should be discussed with the woman in advance.
- Feticide should be carried out or directly supervised by a Subspecialist Consultant in Fetal Medicine or a Fetal Medicine Specialist with equivalent training and experience. The assistant for the procedure may either be a trained Fetal Medicine midwife or trained doctor. It should be discussed and agreed with the assistant what their tasks

during the procedure will be. This should include whether they are comfortable obtaining a fetal blood sample (if required) and injecting the drug to induce asystole.

- Fetal pain is difficult to ascertain and measure[23]. There is a lack of evidence of fetal pain perception <28+^{0} weeks, fetal pain perception is anatomically plausible beyond 28 weeks, but with lack of evidence that it occurs[23]. There is evidence that a fetal stress response to noxious stimuli may be reduced by fetal analgesia and that fetal analgesia is safe for the fetus and woman. Practitioners should be mindful of women's concerns and wishes about fetal awareness and/or pain. Gestational age, procedural complexity and practitioner expertise should be reviewed when considering fetal analgesia. Practitioners performing feticide at gestations below 28+^{0} weeks' gestation should not routinely offer or discuss the use of fetal analgesia. Practitioners performing feticide at 28+^{0} weeks' gestation or above should consider and discuss the option of fetal analgesia. Fentanyl can be used to provide fetal analgesia prior to injection of potassium chloride (KCL). Lidocaine is a local anaesthetic with analgesic properties, where lidocaine is used as the feticide agent, no additional agent for fetal analgesia would be required.

Procedures for singleton pregnancies and dichorionic multiple pregnancies

- All procedures are to be performed under aseptic conditions according to the unit's SOP and using continuous ultrasound guidance
- Equipment and medication drawn up should be placed on a sterile trolley. All medication syringes should be clearly labelled or easily identifiable from each other.
- Fentanyl preparation using 100 micrograms / 2ml vials. The fetal dose advised is 10 mcg/kg of estimated fetal weight. Whilst fentanyl can be given neat, it is difficult to administer very small volumes accurately and dilution is recommended (see section 7.3 for dilution protocols).
- For all procedures requiring fetal intravascular injection, it is good practice to confirm intravascular needle placement by assessing for flashback/aspirating a small volume of fetal blood and/or saline flush prior to injection of the feticide agent. Procedures with central injection to the fetal cardiovascular system, usually into a cardiac ventricle or major vessel, are most effective in causing rapid onset of asystole and sustained asystole. Agents that reliably induce sustained asystole via fetal intravascular injection include 15% KCL and 1% Lidocaine. With appropriate central vascular needle placement, less than 10ml of either of these agents is usually required to induce sustained asystole.
- Cannulation and injection into the umbilical vein at the placental cord root is also feasible with an anterior placenta or lateral placenta with accessible cord root. This route does not require any fetal contact and may be more acceptable to some women. Very careful mapping with greyscale imaging, pulsed and colour flow Doppler is required to ensure entry and injection into the umbilical vein and avoidance of the umbilical artery. Inadvertent injection into the umbilical artery may cause the drug used in feticide to enter the maternal circulation and can cause significant adverse impact for the mother, dependent on the drug. For this reason, only lidocaine should be used for cord root umbilical vein injection. Caution is required when considering this route in the third trimester as large volumes of 1% lidocaine (30-40 ml) may be required to cause primary asystole and careful reassessment should be carried out due to the higher risk of fetal autoresuscitation.
- If the woman has opted for fetal analgesia, Fentanyl should be administered to the fetus. In practice the advised method is to gain fetal intravascular access (intracardiac or cord root umbilical vein) and administer fentanyl immediately prior to KCL.
- Planned or inadvertent intrafetal injections (pericardial, intrathoracic) may result in fetal demise due to cardiac tamponade and/or localised absorption of cardiotoxic or arrhythmogenic drug, but these injections may be less reliable and require careful reassessment that asystole is maintained. Intraamniotic injections to cause fetal

demise are described in some settings but are not standard practice within Fetal Medicine.

- After fetal injection of the agent used for feticide and asystole, it is advised to leave the procedure needle in place and reassess that asystole is sustained over a period of 5 minutes. If there is delay in achieving asystole or fetal heart pulsations return when reassessed, a further injection of a feticide agent, at the same doses and volumes advised above, should be given and steps to observe for sustained asystole followed. The procedure needle can be removed once sustained asystole of greater than five minutes has been confirmed.

Procedures for monochorionic multiple pregnancies

Procedures are to be performed in Liverpool Women's Hospital, under aseptic conditions according to the unit's SOPs and using continuous ultrasound guidance or under direct fetoscopic vision.

Selective feticide of an affected fetus in a monochorionic multiple pregnancy should be performed by a vascular occlusion procedure. The most appropriate surgical approach is dependent upon gestational age, individual pregnancy factors and operator expertise. The LWH Fetoscopy SOP will be followed. Procedures include intrafetal laser (<14 weeks), radiofrequency ablation (<15-weeks) and umbilical cord occlusion (using laser or diathermy) at later gestations. Procedures become more technically challenging as pregnancy progresses into the third trimester. In this situation the woman requires specialised counselling about their options with a subspecialist consultant able to perform techniques for termination in monochorionic multiple pregnancies. This can be offered for in LWH Multiple Pregnancy Clinic.

Demise of the remaining fetus (or fetuses) or preterm birth with associated morbidity and mortality, remains a risk with any selective feticide procedure. The multiple pregnancy team should counsel about the need for further imaging for the surviving co-twin following selective feticide.

After the procedure

With confirmed fetal vascular injections and sustained asystole at the 5-minute post-procedure assessment, further assessment for fetal heart pulsations is not required. However, operators should be cautious where there may have been initial entry and injection into the pericardium or intrathoracic injection, further dosing requirement and/or greater than 5 minutes to achieve asystole. In such cases the operator should consider reassessment for fetal heart pulsations at a 15-30-minute interval from the initial asystole. Routine reassessment for fetal heart pulsations can also be performed at the operator's discretion and/or where this is required in the unit's SOP. The procedure and a clear plan for follow-on care should be documented in the woman's electronic patient record and should be visible to all professionals involved in post termination care. Where procedures are documented on a separate reporting system this requires integration of that reporting system with the EPR or copying procedural information and the plan into the EPR to ensure staff delivering further care are fully informed. Some women may prefer to be admitted to hospital following the procedure, this should be discussed with the clinical team and emotional and psychological needs should be supported.

There should be a high index of suspicion for complications if a woman has an unplanned attendance at an assessment unit or requires admission following feticide, MTOP or STOP. There is a risk of procedure-related or ascending infection following feticide, STOP or MTOP, respectively. Infections, visceral and vascular injuries can become serious maternal risks, reflected in MBRRACE case histories for women that die. We are not currently accurately capturing maternal morbidity for complications following feticide, MTOP and STOP procedures.

Women attending unplanned following feticide, MTOP or STOP should be assessed by a

senior obstetric doctor (ST6-7 or Consultant). A detailed history should be taken, clinical examination, including modified early obstetric warning score (MEOWS) should be carried out . There should be a low threshold to obtain maternal blood samples for FBC, lactate (blood cultures if pyrexial) and a high vaginal swab[24]. Consideration should be given to the most appropriate place of care, dependent on maternal condition and suspected diagnosis, including considering early transfer to a unit where critical care is available[24].

Where a woman presents unplanned following a feticide, this should be communicated to the fetal medicine unit where the procedure was performed without delay. Where a woman presents to a different unit than where MTOP or STOP was performed, this attendance should be communicated to the unit where the procedure was carried out.

5.10 Recommended methods to induce delivery

There is good evidence for safety and acceptability of regimens containing mifepristone and misoprostol in managing early and mid-trimester loss and stillbirth. There is limited evidence to guide the specific choice of mifepristone and misoprostol regimen in termination cohorts, and in women with previous caesarean section.

The guidance in this section aligns with existing national and Northwest regional guidance on termination of pregnancy, mid trimester loss and stillbirth and takes account of regional outcomes and experience. Place of care after admission (gynaecology or obstetrics) and gestational ages to guide the most appropriate place for care should be locally agreed. Complex mid-trimester cases that may benefit from care on Delivery Suite should have fetal medicine consultant to delivery suite consultant discussion to agree an individualised plan.

Pre-induction

Mifepristone is an anti-progestogenic steroid used as pre-treatment. It facilitates the uterine response to subsequent prostaglandins. Contraindications include; uncontrolled or severe asthma, chronic adrenal failure and acute porphyria. Cautions include; asthma, risk factors for cardiovascular disease, prosthetic heart valves or endocarditis and haemorrhagic disorders.

The use of a combination of mifepristone and misoprostol increases the chance of vaginal birth and reduces the number of doses of misoprostol required when compared to the use of misoprostol only[25,26].

A single dose 200 milligram oral mifepristone is given. The interval between administration of mifepristone and misoprostol can be 0 to 48 hours[26]. For TOPFA <13+^{0} standard protocol (24–48-hour mifepristone – misoprostol is advised, in-keeping with Northwest Midtrimester Loss Guidance). A choice of short protocol (0–24-hour interval mifepristone – misoprostol) or standard protocol can be offered from 13+^{0} weeks (see flowcharts for women with unscarred and scarred uterus below)[27]. The choice of short or standard protocols should take into account the woman's wishes and accommodating the admission for misoprostol in the appropriate unit. At all gestational ages, and including where there is a uterine scar, it is reasonable to manage the woman as an outpatient after mifepristone administration and admit for misoprostol administration, unless she opts for early admission.

Pain Relief

Ensure the woman has adequate analgesia and that analgesia does not need to follow the routine pathway for vaginal births. Options for analgesia should be discussed in advance of induction beginning. Offer the opportunity to speak to the obstetric anaesthetist to discuss analgesic options in advance of commencing induction.

All analgesic modalities should be made available, including regional analgesia and patient-controlled analgesia, and the analgesic plan should be tailored for the woman, considering

any specific contraindications. If intramuscular opiate analgesia is chosen, then diamorphine should be used in preference to pethidine as it is more effective. If patient-controlled analgesia is chosen, fentanyl may be more appropriate than remifentanil. ***Induction medications***

Misoprostol (prostaglandin E1) is the prostaglandin usually used first line, to induce delivery during MTOP.

Cautions include; inflammatory bowel disease, conditions that are exacerbated by hypotension (e.g. cerebrovascular or cardiovascular disease).

Side effects include; fever, nausea, vomiting, abdominal cramping and diarrhoea. These are less common if the tablets are given vaginally. Serious complications, including uterine rupture and major haemorrhage are rare.

The dosage of misoprostol to be administered will depend on the gestational age (see below for advised regimes). Misoprostol is available as a 200-mcg scored tablet. 100 mcg doses can be obtained by dividing a 200-mcg tablet into two halves using a pill cutter. Similarly, 50 mcg can be obtained by dividing the ½ tablet into 2 (i.e. ¼ tablet). It is recommended that the pill cutter is used for accurate division.

There is very limited evidence on further medical management if delivery does not occur after misoprostol treatment. Women that do not deliver following the first cycle of misoprostol should have full clinical reassessment by the most senior obstetrician on duty (ST6-7 or Consultant) with fetal medicine input, as required. This review should include transabdominal and transvaginal ultrasound to ensure the fetus is intrauterine and exclude implantation in a non-communicating horn. Where there are no concerns identified, a 12-hour prostaglandin rest period should be recommended, prior to beginning a second misoprostol cycle. Further caution is advised for women who do not deliver following the second misoprostol cycle with full clinical assessment by the Consultant Obstetrician, including further transabdominal and transvaginal ultrasound assessment and input from the Fetal Medicine Consultant, as required.

If there are no concerns identified, the Consultant Obstetrician should have an individualised discussion about further options for the woman. Options include hysterotomy / caesarean section, or further medical management with prostaglandins and/or oxytocin where the woman would prefer to avoid surgery.

In Liverpool Women's Hospital and other units within Cheshire and Mersey, Carboprost 250 mcg IM 3 hourly (up to 8 doses) has been used where mifepristone/misoprostol management has been unsuccessful. Carboprost is resistant to enzymatic degradation and has improved smooth muscle activation and longer duration of action than misoprostol, but also has associated gastrointestinal side effects that should be discussed if this option is considered.

During a 6-year period at LWH (2014 – 2020), 10 women received Carboprost (including 3 women with previous lower-segment caesarean section) during induction at 16+0 – 32+4 weeks after not delivering following two cycles of Misoprostol, all subsequently achieved vaginal delivery of the fetus and placenta with a mean of 2.6 doses of Carboprost,Carboprost – delivery time of <8 hours, and no complications.

Please see flowcharts below for advised steps where misoprostol treatment is unsuccessful for women with an unscarred or scarred uterus.

Women with uterine scars

There are limited studies reporting delivery outcomes for women with uterine scars undergoing MTOP. Similarly, the RCOG Green Top Guidance on Management of Stillbirth reports insufficient evidence to recommend a specific induction regime for women who have had previous caesarean section[28].

For women having TOPFA, the Fetal Medicine Consultant should have an individualised discussion with the woman, considering her obstetric history, views on future pregnancy, the process, risks and benefits of induction and surgical treatment including hysterotomy / caesarean section. MTOP is not recommended for women with previous uterine rupture or upper segment incisions.

Most women having TOPFA will be in the midtrimester. From Northwest regional experience, the majority of women with previous caesarean section(s) misoprostol IOL is a safe and effective means of achieving vaginal birth (see below for mifepristone and misoprostol dosing by gestation). Additionally, If 28 weeks or more and feasible to insert, a cervical ripening method (Cook's catheter or Dilapan) can be offered as an alternative to misoprostol. However, it should be expected that ARM and oxytocin are likely to be required after the cervical ripening method.

Caution is advised in re-assessing women that do not deliver following the first cycle of misoprostol. Where this occurs, there should be full clinical reassessment by the most senior obstetrician on duty (ST6-7 or Consultant) with fetal medicine input, as required. This review should include transabdominal and transvaginal ultrasound to ensure the fetus is intrauterine, assess the integrity of the uterine scar and exclude implantation in a non-communicating horn. Where there are no concerns identified, a 12-hour prostaglandin rest period should be recommended, prior to beginning a second misoprostol cycle.

Further caution is advised for women who do not deliver following the second misoprostol cycle. There is a paucity of evidence on further medical induction of women with uterine scars, following mifepristone / misoprostol. There should be full clinical assessment by the Consultant Obstetrician, including further transabdominal and transvaginal ultrasound assessment and input from the Fetal Medicine Consultant, as required. The Consultant Obstetrician should have an individualised discussion about the options of hysterotomy/caesarean section or further medical induction. Where women prefer to avoid surgery, Carboprost 250 mcg IM 3 hourly (up to 8 doses) can be considered as an alternative prostaglandin that is used in this situation in LWH, including for women with previous caesarean section.

Unscarred and Scarred uterus – up to $10+^{0}$ weeks

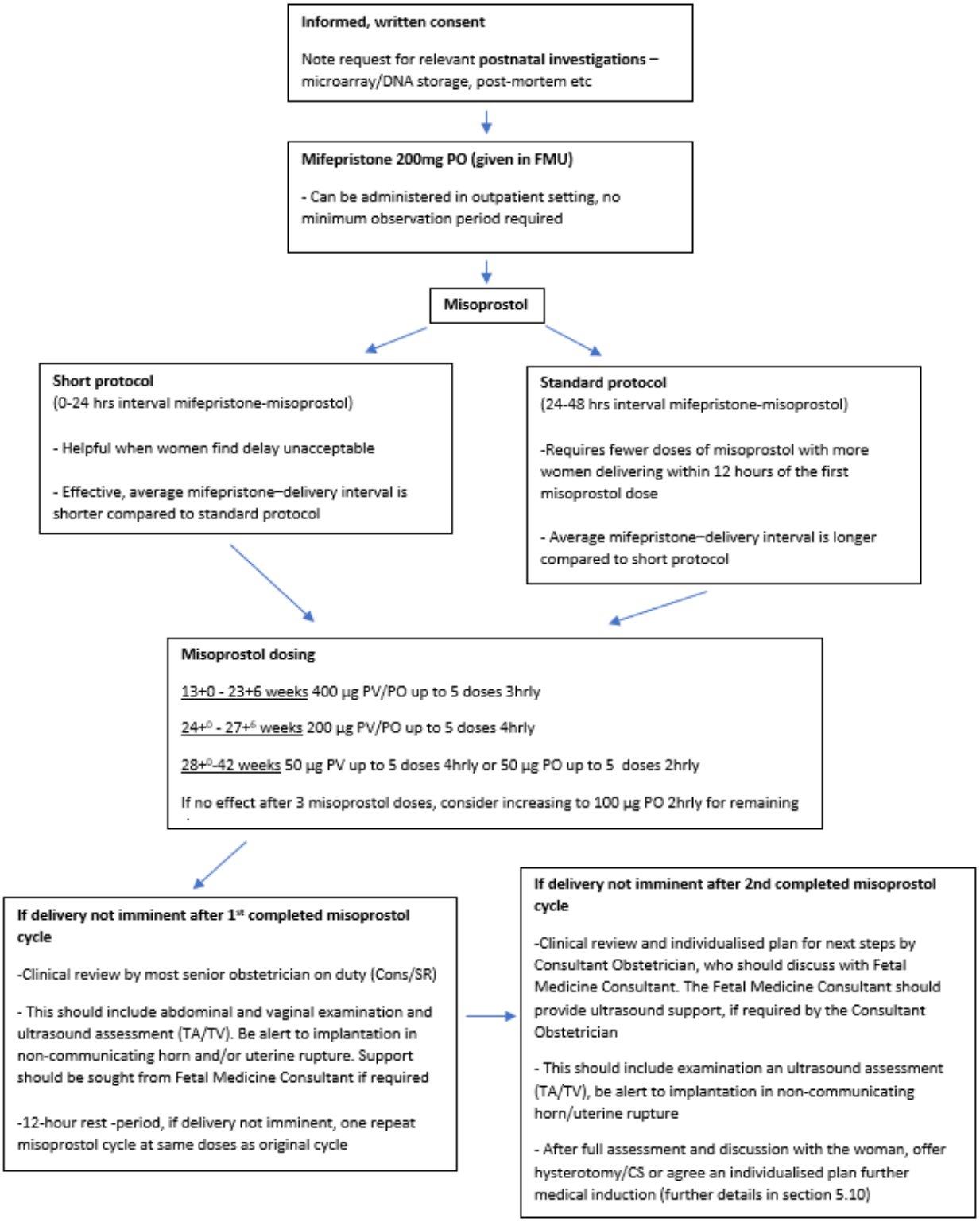
- Mifepristone 200 milligrams orally
- Misoprostol* 800 micrograms for one dose (24-48 hours later)

If $10+^{0}$-$12+^{6}$ weeks

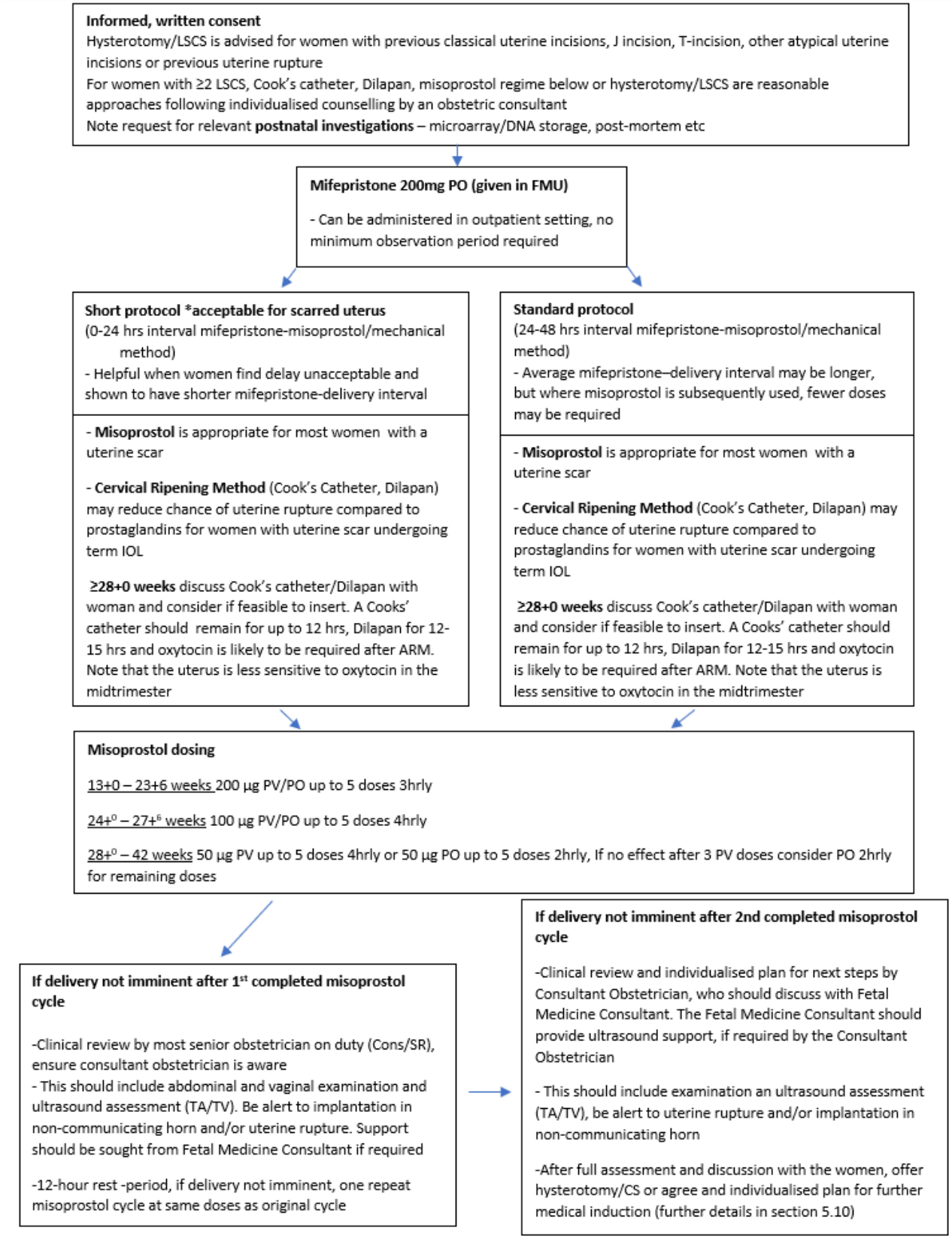
- Continue Misoprostol 400 micrograms 3 hourly for a maximum of 4 doses

* If abortion is not complete following 5 doses of Misoprostol, discuss with a senior Doctor (ST3+).
A second course of Misoprostol can be started after a 12-hour interval.

Unscarred Uterus - 13+^{0} weeks to Term



Scarred Uterus – 13+^{0} weeks to Term



5.11 Care during induction and labour

Women having TOPFA should be admitted to a suitable private room for their care where their emotional and practical needs can be taken into account without compromising their safety. Dependent on gestational age, clinical details and local service this will be provided in a gynaecology setting or within delivery suite.

Care should be given by an experienced nurse or midwife. Ideally one to one care should be facilitated at least for the first 24 hours to support the mother and the family and undertake necessary paperwork, though it is recognised that this may not always be possible during times of high activity in the maternity unit. A Consultant Gynaecologist or Obstetrician (dependent on place of admission) should be made aware of the mother's admission.

Birth choices remain as for all women in labour and the woman's birth plan should be reviewed with her. If medically appropriate, women should be offered the option of delivering their baby in a birthing pool.

Blood tests including full blood count (FBC), clotting screen, and group and save should be performed. Obstetric staff should be vigilant to clinical features that may suggest uterine scar dehiscence/rupture: maternal tachycardia, atypical pain, vaginal bleeding, haematuria and maternal collapse. Contractions should be palpated regularly and MEOWs regularly recorded. A partogram should be used so that trends which may indicate this complication are apparent.

Women with sepsis should be treated with intravenous broad-spectrum antibiotics as per Trust guidelines, including cover for chlamydia (if clinically high risk) after sepsis screening investigations have been performed.

Group B Streptococcus

Women with IUFD and Group B Streptococcal (GBS) colonisation of the vagina do not require antibiotic prophylaxis in labour.

Management of third stage

The third stage should be managed in accordance with local guidance.

5.12 Early Postnatal Care

Thromboprophylaxis

An individual risk assessment should be performed for each mother. Prophylactic low molecular weight heparin should be prescribed where indicated.

Suppression of lactation

This should be discussed and cabergoline 1 mg may be administered orally, unless there are specific contraindications, including maternal hypertension/pre-eclampsia or puerperal psychosis. Human milk donation is also an option. If a bereaved mother expresses a wish to donate, contact the Northwest Human Milk Bank who will talk the family through the donor recruitment process and answer any questions. Alternatively, parents can fill in the online screening form using this link https://www.milkbankatchester.org.uk/donate/donationafterloss

Contraception

This should be discussed before discharge home and advice given to await investigation results and debrief discussion of results and any additional actions before planning pregnancy. FSRH Clinical Guideline Contraception After Pregnancy, available online: https://www.fsrh.org/Public/Standards-and-Guidance/Contraception-After-Pregnancy.aspx28.

5.13 Care of the Baby

Each family's individual and cultural needs should be identified and accommodated. The baby should be weighed, and the birth weight centile calculated and documented.

Contact with baby

Seeing and spending time with their baby can be valuable for parents. Some parents may wish to see and hold their baby immediately after birth, some may prefer to wait, some may choose not to see their baby; their decision should be respected. It may be necessary to prepare parents about their baby's appearance if death occurred some time before the birth. Parents are free to change their minds and can ask to see their baby whenever they feel ready. Parents may wish other family members to be given opportunity to see and/or hold their baby. Some units offer families the use of a pram if they wish to take their baby for a walk.

Parents should be offered the use of the cooling cot to maintain baby's skin condition. The use of the cooling cot can improve the quality of bereavement care as it allows parents to spend more time with their baby and enhances their lasting memories. https://cuddlecot.com/cuddlecot/

Mementos

Mementos should be offered and obtained once the parent's verbal consent has been given. These may include a lock of hair (depending on gestation) or hand and footprints, cord clamp, tape measure used to measure baby, cot card, and identity band. If appropriate, parents can be offered a baby bath. Most parents welcome these tokens, and they can be presented in memory boxes. Many charities offer memory boxes (for example 4Louis, Sands). Parents may wish to keep the linen from delivery or linen from incubator or cot and clothes baby was wearing.

If photographs are taken, these should be stored as per Trust guidelines. If mementos and/or photographs are requested but not taken home by parents, it may be possible to store these in the hospital records should the parents wish to access them at a later date. If it is not possible to store photographs in the hospital records (e.g., due to electronic record systems), these should be offered in a sealed envelope for parents to store at home.

Photographs of baby

Photographs of the baby are valuable and can be taken with the parents' own camera or with the hospital digital camera. If there is a multiple birth, photographs of the babies may be taken together and/or separately. Suggest different photos including family groups, photos of hands and feet and with baby dressed and undressed.

Taking photographs with the hospital digital camera requires parental verbal consent. Similarly, verbal or written consent may be required for photographs to be taken by medical photography (consult local Trust policy). Identification of the start and end of a series of photographs must be performed. An additional option is via local children's hospices, who may offer professional photography for parents losing their baby before, during or shortly after birth.

Transfer of baby to the mortuary

Prior to transferring the baby to the mortuary, provide parents with the opportunity to spend special time with their baby.

Ensure that the baby has been properly identified. Recommendations for this include applying two completed name bands e.g. “Baby of (Mother’s Name), Mother’s Identity Number, date and time of birth as well as the hospital name”. Some Trusts use body labels as well, if this is the case, the card should read ‘baby of (Mother’s Name) and not as if it is the mother who has died.

If the parents have given their baby personal items (teddy etc.) they should remain with the baby, (unless the parents change their mind), these can be labelled using identification bands.

Prior to transfer to the mortuary some Trusts wrap the baby in a sheet or place in infant body bag, ensuring that all body parts including the face are covered. Attach a second cot card or insert and handover information sheet into the transport window of the infant body bag (if used).

Arrange transfer and if parents wish to accompany their baby, notify the anatomical pathology technician (APT) and bereavement team first. A member of maternity staff must accompany the family. The family may wish for the funeral director to collect the baby from the maternity unit rather than the mortuary. Please discuss this with the individual funeral director.

Taking baby home

Occasionally the family may wish to take their baby home or to a place which has a special significance for them. This is not always ideal as the baby may deteriorate rapidly and parents should be informed of this, especially if they wish to have a post-mortem. The parents’ wishes should be supported. There is no legal reason why they cannot take their baby home or directly to the funeral directors of choice. The baby must be taken home in an appropriate casket or Moses basket. The transport home must be appropriate i.e. private not public transport. The mortuary must be informed if the parents are taking their baby home.

Some hospices offer the use of a cold room facility. This allows the family to stay with the baby and say goodbye in a supportive environment. This is a place where babies can lay at rest after their death until the day of their funeral.

For further reading see; https://www.neonatalnetwork.co.uk/nwnodn/palliative-care/

https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/02/Hospice-Information.pdf

If the parents would like the hospital to help them with the funeral arrangements, refer to local hospital policy. Document what arrangements are likely to be carried out. If the family choose a cremation from $24+^{0}$ weeks cremation form 9 should be completed, this can be done by a midwife, below $24+^{0}$ weeks a non-viable fetus form should be completed. The funeral director will complete Cremation Form 3.

Returning to see their baby

After the parents have returned home, they can arrange to return to hospital to see their baby. Advise the parents how to make these arrangements should they wish.

When such a request is received:

1. Obtain the parents’ contact number.

2. Check whether the baby is still on hospital premises. This is particularly important if the baby was transferred out for post-mortem.

Viewings are arranged on an individual basis only at the referring hospitals.

3. Inform parents of the name of the person who will meet and accompany them.

4. Check that the baby is lying peacefully in the Moses basket; (with/wearing any clothing or items that have been specified by the parents).

5.14 Communication and follow-up

Teams should continue to care in line with regional and/or local guidance.

Information sharing

The Community Midwife, GP and Health Visitor should be notified of the outcome, with the woman's consent, and appointments amended appropriately. If a woman has shared care, the neighbouring trust and specialist services should be informed. If the woman has ongoing psychological or a known psychiatric disease, the GP and health visitor should be made aware of this to ensure optimisation of care in the community.

Bereavement support

To provide compassionate and appropriate postnatal care for women, families and their babies, midwives should continue to use the relevant guideline and pathway, and this will be dependent on the classification of the death late fetal loss, stillbirth or neonatal death.

Women and families should be offered continuing bereavement support; usually from a bereavement support midwife or counsellor. They may be able to offer continuity and psychological support in subsequent pregnancies. Information about ongoing support, including counselling and groups should be offered.

5.15 Further investigations

The fetal medicine consultant should discuss further investigations that may be helpful in identifying the cause of fetal anomalies and/or informing care in a future pregnancy with women.

The rationale for advising investigations or further investigations not being required, should be included in the fetal medicine report, along with the women's expressed wishes for investigations, at that time. Where a definitive chromosomal or genetic diagnosis has been identified during pregnancy, further investigations are usually not advised. This documentation should be reviewed by the Delivery Suite Consultant, to inform any further discussions and consent required, after delivery.

Women should be advised to await results of investigations they opt for and counselling with these results prior to a future pregnancy. This is important to determine any chance of recurrence and ensure an appropriate management plan can be put in place.

Investigations to consider include;

Postmortem examination

Women should be informed that full post-mortem is the investigation most likely to provide information that influences management in a future pregnancy. Women should be provided with written patient information (see section 7.4 for Northwest consent forms). There are options to tailor postmortem to what women find acceptable, including, full, limited (to include

external examination, imaging and biopsies and/or specific regions of the body) and external examinations only. Placental histology and, where there are fetal anomalies, fetal chromosomal analysis, is assessed as part of the postmortem examination, unless the woman opts against these for any reason. In this instance the placenta and cord should be bagged and delivered fresh to the mortuary and **NOT** stored in a fixation agent. Accurate phenotyping can allow access to further genetic investigations to make a definitive diagnosis.

Where any post-mortem takes place for a fetus with known anomalies, findings are discussed at a regional multidisciplinary dysmorphology meeting (Liverpool or Manchester regions). These meetings include representation from Pathology, Clinical Genetics, Radiology and Fetal Medicine and agree if further investigations are indicated e.g., whole genome sequencing (WGS) and referrals required e.g., Clinical Genetics.

Where post-mortem examination (including limited examination) is indicated, but is declined, examination of the baby after birth by a clinical geneticist or neonatologist should be considered and discussed with the woman.

Placental histology

See section 7.5 for Northwest request forms. The placenta should be fixed in the advised preservative as per local policy (e.g., formalin). If the placenta cannot be fixed in formalin, it should be refrigerated and sent to the laboratory at the earliest opportunity. Report all infectious agents to the pathologist (for example coronavirus, hepatitis, HIV).

Fetal chromosomal assessment (microarray)

Should be offered via biopsy on the fetal side of the placenta adjacent to the cord insertion, see section 7.6 for Northwest referral criteria and request forms. Please use Section 6 of the Postmortem Consent Form in section 7.4. Complete the statement box on referral form *"It is the referring clinician's responsibility to ensure that the patient/carer knows the purpose of the test and that the sample may be stored for future diagnostic tests"*. Cord samples should be taken prior to placing the placenta in formalin or other preservative as per local policy. If the placenta cannot be fixed in formalin, it should be refrigerated and sent to the laboratory at the earliest opportunity. Report all infectious agents to the pathologist (for example coronavirus, hepatitis, HIV).

Other specific investigations

Additional investigations may be advised by the fetal medicine and/or clinical genetics teams in individual cases. These are dependent on fetal appearance or condition e.g. virology (including if woman has screened negative at booking – e.g., syphilis), antibody testing.

5.16 MBRRACE-UK and PMRT

MBRRACE-UK conducts surveillance of all eligible perinatal deaths occurring in the UK.

Deaths eligible for reporting to MBRRACE-UK following termination for fetal anomaly and inclusion in surveillance are:

- Stillbirths – the baby is born from 24 completed weeks' gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.

- Neonatal deaths – the death of a live born baby born from 20 completed weeks' gestation (or from 400g where an accurate estimate of gestation is not available) occurring before 28 completed days after birth.

Completion of the Perinatal Mortality Review Tool (PMRT) is not required following termination

for fetal anomaly resulting in stillbirth. PMRT is also not required in the context of livebirth that occurs following termination.

Further information is available at:

https://www.npeu.ox.ac.uk/pmrt

https://www.sands.org.uk/our-work/fewer-baby-deaths/learning-lessons/national-perinatal-mortality-review

5.17 Debriefing

Discuss with women the option of postnatal debrief, when this can take place and that this may be offered face to face, virtually or by telephone, tailored to their needs and preferences. If women do not wish to have a debrief appointment an alternative is to have a letter with information for them to refer to, also to be shared with the woman's GP. Access to a debrief appointment or pre-pregnancy counselling should be offered for the future.

If the baby has been given a name, health care professionals should ensure they use the baby's name in all future discussions and written communications.

5.18 Support for staff providing termination of pregnancy for fetal anomaly

Involvement with termination of pregnancy, including where feticide is required, trigger trauma responses in clinical staff[29]. Supportive team relationships help with control of emotional expression and clinicians do not become distressed if they feel termination for fetal anomaly aligns with their values and legal options[28].

Team culture and informal peer support should be encouraged as a proactive support for clinical staff involved in termination for fetal anomaly. Clinical managers should be mindful of the potential for trauma responses and familiarise themselves with their unit's policies for time out of work after a traumatic event and options for specialist support for staff. There is increased interest in responses to work related trauma and development of effective staff support. Case discussion groups and access to psychological support may be beneficial for clinical staff involved in termination of pregnancy. Access to formal support varies by unit, some units will have specific access to staff psychology and / or maternity counsellors, where staff can self-refer to access one to one support. Support can also be accessed via professional midwifery advocates and occupational health Provision of appropriate staff support should be factored into fetal medicine service development in the Northwest.

6 Monitoring

This guideline and the associated integrated care pathway have been peer reviewed by the Regional Guidelines Group. The documents will be updated via a similar peer review process after three years. Each maternity provider should agree a process for auditing local compliance with the guideline.

7 Appendices

7.1: HSA1, HSA2, HSA4 Forms and registering stillbirth

https://assets.publishing.service.gov.uk/media/5a7bfdb0e5274a7202e18dc6/HSA1-form.pdf

https://assets.publishing.service.gov.uk/media/5a7bac0640f0b638d61be30f/HSA2-form.pdf

https://www.gov.uk/government/publications/abortion-notification-forms-for-england-and-wales/form-hsa4-abortion-notification-summary-of-the-information-collected

https://www.gov.uk/government/publications/abortion-notification-forms-for-england-and-wales/guidance-notes-for-completing-hsa4-electronic-forms

7.2 Registering a stillbirth and baby loss certificates

https://www.pi.nhs.uk/pnm/ReCoDe_Classification.pdf

https://www.gov.uk/register-stillbirth

https://www.gov.uk/request-baby-loss-certificate

7.3 Fentanyl Dilution Protocol

(With thanks to Pranav Pandya and Alia Husain for production and review of fetal analgesia protocols, reproduced from BMFMS Position Statement on Fetal Pain and Fetal Awareness Advice for clinicians performing fetal interventions March 2025)

Dosing:
Fentanyl 10 microgram/kg IM or IV

Clinical:
Fentanyl to be drawn up and placed on sterile trolley along with other equipment and any other medication being used. All medication syringes should be clearly labelled or easily identifiable from each other.

Medication preparation:

- Fentanyl 100 micrograms / 2ml is used.
- Whilst fentanyl can be given neat, it is difficult to administer very small volumes accurately and so dilution is performed to enable this.

For fetuses below 1kg estimated fetal weight

- Draw up 2ml (100 micrograms) of neat fentanyl and add 8ml water for injection to give a final solution of 100 micrograms in 10ml.

- See Table 1 for volume required depending on weight. Expel and discard all excess volume.

Table 1:

Estimated Fetal Weight (Kg)	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9
Fentanyl prescribed (mcg)	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0
Final solution volume (ml)	0.20	0.30	0.40	0.50	0.60	0.70	0.80	0.90

For fetuses with an estimated fetal weight of 1kg and over

- Draw up 0.8ml (40 micrograms) of neat fentanyl into a 1ml syringe.
- See Table 2 for volume required depending on weight. Expel and discard all excess volume.

Table 2:

Estimated Fetal Weight (Kg)	1.0	1.25	1.5	1.75	2.0	2.25	2.5	2.75	3.0	3.25	3.5	3.75	4.0
Fentanyl prescribed (mcg)	10.0	12.5	15.0	17.5	20.0	22.5	25.0	27.5	30.0	32.5	35.0	37.5	40.0
Fentanyl volume (ml)	0.20	0.25	0.30	0.33	0.40	0.45	0.50	0.55	0.60	0.65	0.70	0.75	0.80

7.4 : Post-mortem documentation

https://www.sands.org.uk/sites/default/files/Deciding%20about%20a%20post%20mortem%20LINKED.pdf

Cheshire and Merseyside, Lancashire and South Cumbria
post-mortem-examination-hst-information-leaflet.pdf

Post-mortem-consent-form-Alder-Hey-0214_recd-07.10.16.pdf

Examination-of-fetus-form_Alder-Hey-recd-10.10.16.pdf

Greater Manchester and Eastern Cheshire
POST-MORTEM-CONSENT-MFT-2021.pdf

POST-MORTEM-Consent-Help-Sheet-MFT-External-2021.pdf

7.5: Placental Histology

Cheshire and Merseyside, Lancashire and South Cumbria
Histology-form_SHK-recd-10.10.16.pdf

Alder-Hey-Sample-Request-form-for-Placental-Examination-V1-04.25.pdf

Greater Manchester and Eastern Cheshire
Request Form for Histopathological Examination of Placenta

Placenta-instructions-ver4-200716.pdf

7.6: Cytogenetic Testing

Cheshire and Merseyside, Lancashire and South Cumbria : Liverpool Women's Hospital 0151 702 4229.
Current forms can be printed from Genetic Laboratory Services - Liverpool Womens NHS Foundation Trust or genetics-referral-form-feb-2020.pdf
LWH-Cytogenetics-Form-V1-04.25.pdf

Greater Manchester and Eastern Cheshire: St Mary's Hospital 0161 276 6553
Current forms can be printed from www.ManGen.org.uk/useful-forms
Cytogenetics-referral-form-Manches.. .pdf

7.7 Support Organisations and Groups

Regional

Children of Jannah
Support for bereaved Muslim families in the UK, based in Manchester.
Helpline: 0161 480 5156
Email: info@childrenofjannah.com
Website: www.childrenofjannah.com

CRADLE
Providing support to anyone affected by the death of a baby during pregnancy, or termination of pregnancy.
Website: https://cradlecharity.org/

Listening Ear
Free self-referral counselling to help deal with anxiety, bereavement and depression.
Helpline: 0151 488 6648
Email: enquiries@listening-ear.co.uk
Website: http://listening-ear.co.uk/

Once Upon A Smile
Children's bereavement support
Phone: 0161 711 0339
Website: www.onceuponasmile.org.uk

The Alder Centre
Providing care and education for anyone affected by the death of a child, at any age
Phone: 0151 252 5391
Website: https://www.alderhey.nhs.uk/the-alder-centre/

National

Antenatal Results & Choices (ARC)
Support for parents whose baby is diagnosed with a fetal abnormality in pregnancy.
Helpline: 0207 713 7356 (available Tuesday & Thursday evenings 8pm to 10pm).
Email: info@arc-uk.org
Website: www.arc-uk.org/

Child Bereavement UK

Advice and support for children, young people, parents and families when a child grieves or when a child dies
Helpline: 0800 02 888 40
Website: https://www.childbereavementuk.org

Cruse Bereavement Care
For adults and children who are grieving.
Helpline: 0808 808 1677
Website: https://www.cruse.org.uk/get-help

Daddies with Angels
Advice and support to male family members following the loss of a child/children.
Website: https://www.daddyswithangels.org/

Ellie's Gift
App and website for baby loss support for parents and professionals
Website: https://www.ellies.gift/

Jewish Bereavement Counselling Service:
Supporting Jewish individuals through loss and bereavement
Helpline: 020 8951 3881
Email: enquiries@jbcs.org.uk
Website: www.jbcs.org.uk

Lullaby Trust
Bereavement support to anyone affected by the sudden and unexpected death of a baby.
Helpline: 0808 802 6868
Email: support@lullabytrust.org.uk
Website: http://www.lullabytrust.org.uk

MIND
Supporting people with mental health problems.
Infoline: 0300 123 3393
Website: http://www.mind.org.uk/

Muslim Bereavement Support Service
Serving the Muslim community by supporting bereaved women who have suffered a loss
Website: https://www.ataloss.org/

Petals Baby Loss Counselling Charity
Free counselling service to support women, men and couples through the devastation of baby loss.
Helpline: 0300 688 0068
Website: www.petalscharity.org

Samaritans
Confidential emotional support in times of despair. Telephone: 116 123
Website: www.samaritans.org

SANDS
Advice and support for anyone affected by baby loss
Helpline: 0808 164 3332
Website: https://www.sands.org.uk/

Saneline

Emotional support and information for people with mental health problems
Phone: 0845 7678000
Website: http://www.sane.org.uk/

Tommys
information and support for anyone who has experienced the loss of a baby, whether through miscarriage, stillbirth, neonatal death, or termination for medical reasons.
Midwives' helpline: 0800 0147 800 or email midwife@tommys.org.
Black and mixed heritage helpline: https://www.tommys.org/pregnancy-information/about-tommys-pregnancy-information/video-call-service (to book a call)
Website: https://www.tommys.org/baby-loss-support

Twins Trust
Bereavement and special needs support groups
Email: enquiries@twinstrust.org
Website: www.twinstrust.org/bereavement

The Compassionate Friends UK
Offering support to bereaved parents and their families
Helpline: 0845 123 2304
Email: info@tcf.org.uk
Website: www.tcf.org.uk

8 Supporting references & national guidance

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9 Definitions / glossary

AFP – Alpha fetoprotein

BMA - British Medical Association

EPR – Electronic patient record

FASP – Fetal Anomaly Screening Programme

GMC - General Medical Council

Ground C - Ground of the Abortion Act 1967 that permits termination of a pregnancy (or fetus) when two doctors agree that 'the pregnancy has not exceeded it's 24th week and that the continuance of the pregnancy would involve risk greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman.

Ground E - Ground of the Abortion Act 1967 that permits termination of a pregnancy (or fetus) when two doctors agree that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

HCG - Human Chorionic Gonadotrophin

KCL – Potassium chloride

NIPT - Non-invasive prenatal testing, high-performing fetal aneuploidy screening test based on analysis of circulating cell-free fetal DNA in the maternal circulation

NMC - Nursing and Midwifery Council

NT – Nuchal translucency

MBRRACE UK - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

MEOWS - Modified early obstetric warning score

MTOP - Medical termination of pregnancy

PAPP-A - Pregnancy-associated plasma protein A

pES – Prenatal exome sequencing

PMRT – Perinatal mortality review tool

RCOG - Royal College of Obstetricians and Gynaecologists

STOP – Surgical termination of pregnancy

TOPFA – Termination of pregnancy for fetal anomaly or termination for fetal anomaly

uE3 – unconjugated oestriol

UKNSC - UK National Screening Committee

10 Consultation with Stakeholders

This guideline has been developed in Paralell with Northwest Stillbirth Guidance. The guidance has been co-authored with a patient advocate and with input from Jane Fischer, Chief Executive of Antenatal Results and Choices.

11 Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the group to identify where a policy or service may have a negative impact on an individual or particular group of people.

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Northwest Management of Termination for Fetal Anomaly Guideline
Directorate and service area:	Maternity
Is this a new or existing Policy?	New
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Dr Kate Navaratnam Consultant in Maternal-Fetal Medicine
Contact details:	0151 708 9988 ext.4608 or mobile via switchboard

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Fetal medicine specialists and all staff involved in termination care in their roles. This will include obstetricians and gynaecologists, postgraduate doctors working in obstetrics and gynaecology, fetal medicine midwives and other midwives involved in termination and bereavement care.
2. Policy Objectives	To provide comprehensive, up to date and localised guidance on termination for fetal anomaly in the Northwest with the aim of supporting optimal care for women having termination for fetal anomaly.
3. Policy Intended Outcomes	To facilitate optimal, family centered and compassionate care around termination for fetal anomaly.
4. How will you measure each outcome?	
5. Who is intended to benefit from the policy?	Women and families experiencing termination for fetal anomaly, healthcare staff providing care for women who have termination for fetal anomaly.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: *Yes* • Patients/ visitors: *Yes* • Local groups/ system partners: *Yes* • External organisations: *Yes* • Other: *No*
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Please see authors and contributors constituting the multidisciplinary developer group. Mrs Ashley Bird, as patient advocate and the Northwest Guidance Committee.
6c. What was the outcome of the consultation?	All comments received were considered to improve the quality of the documents. Guideline scope and content were agreed with the multidisciplinary developer group, content was drafted, reviewed and revised for regional consultation.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** Retrospective analysis of TOPFA outcomes at LWH, staff and patient feedback.

7. The Impact
Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	*No*	
Sex (male or female)	*No*	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	*No*	
Race	*No*	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	*No*	
Religion or belief	*No*	
Marriage and civil partnership	*No*	

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	*No*	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	*No*	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.
I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy. Name of person confirming result of initial impact assessment: Dr Kate Navaratnam Consultant in Maternal-Fetal Medicine and Honorary Senior Lecturer, Chair of the Cheshire & Mersey Local Maternity System Fetal Medicine Network .....